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George J. Annas

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Reconciling *Quinlan* and *Saikewicz*: Decision Making for the Terminally Ill Incompetent

George J. Annas, J.D., M.P.H.*

ABSTRACT

One of the most perplexing problems in the medicolegal field concerns the criteria on which decisions not to treat terminally ill incompetent patients should be made. These decisions traditionally have been made by physicians in hospitals—sometimes with the assistance of the patient's family—on the basis of their perceptions of the patient's "best interests." Recently, two state supreme courts have ruled on this question. The New Jersey Supreme Court, in the *Quinlan* case, developed a medical prognosis criterion, and permitted the patient's guardian, family, and physicians to apply it with the concurrence of a hospital "ethics committee." The Massachusetts Supreme Judicial Court, in the *Saikewicz* case, adopted, on different facts, the test of "substituted judgment" to be applied by a probate court after an adjudicatory hearing. The two cases have been interpreted by many in the medical profession as representing conflicting viewpoints—one supportive of traditional medical decision making and the other distrustful of it.

It is the thesis of this Article that *Quinlan* and *Saikewicz* are in fundamental agreement and can be reconciled by the next state supreme court that rules on this question. Both courts enunciate a constitutional right to refuse life-sustaining treatment, based on the right to privacy. They agree that incompetents should be afforded the opportunity to exercise this right, and that certain state interests can overcome it. They agree also that physicians should be permitted to make medical judgments, and that societal judgments belong in the courts. The differences in how the opinions are perceived result from the interplay of several factors: the differences in the facts of the cases; the inarticulate use of the term "ethics committee" by the *Quinlan* court; the literal interpretation of the role of such a committee by the *Saikewicz* court; a desire for 100 percent immunity on the part of physicians and hospital adminis-

* Associate Professor of Law and Medicine, Department of Socio-Medical Sciences and Community Medicine, Boston University School of Medicine; Editor-in-Chief, *Medicolegal News*.

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trators in Massachusetts; and advice from their counsel on how such immunity can be guaranteed.

It is the author's hope that this Article will help to dispel much of the misinformation surrounding these two cases, and to refocus the debate on how decisions should be made for the terminally ill incompetent patient on the real issues regarding criteria and the decision-making process that remain to be resolved.

I. INTRODUCTION

In one of his *Letters from the Earth*, Mark Twain has Satan observe that, before hell was invented, "death was sweet, death was gentle, death was kind . . . when man could endure life no longer, death came and set him free." Our mortality is also the subject of one of the first syllogisms taught in logic: All men are mortal. Socrates is a man. Therefore, Socrates is mortal. The modern version of this syllogism might run: All people die in hospitals. Hospitals exist to prevent death. Therefore, an attempt will be made to prevent the deaths of all people.

While overstating the case somewhat, this latter syllogism illustrates the quandary of modern man confronted with his own mortality in the hospital setting. All of us will die, most in hospitals. But new technologies and treatments can save lives and sustain bodily functions where previously death was inevitable. Sometimes these technologies only prolong the dying process and create what Twain might have labeled a hell on earth. Choices must be made. Should the ventilator be turned off? Should intensive chemotherapy be used to treat an invariably fatal cancer? Should only palliative treatment be administered? The modern question is not how death can be prevented, but how much effort, if any, should be made to postpone the moment of death. Because such decisions usually take place in hospitals, physicians generally have assumed that—at least in the case of incompetent patients—such decisions are properly medical ones.¹

¹ There is a large and growing literature on the problems confronting dying patients in hospitals. Some of the best volumes include *THE DYING PATIENT* (O. Brim ed. 1970); *ETHICAL ISSUES IN DEATH AND DYING* (R. Weir ed. 1977); H. FEIFEL, *NEW MEANINGS OF DEATH* (1977); E. KÜBLER-ROSS, *ON DEATH AND DYING* (1969); D. SUDNOW, *PASSING ON* (1967); R. VEATCH, *DEATH, DYING AND THE BIOLOGICAL REVOLUTION* (1976); G. WILLIAMS, *THE SANCTITY OF LIFE AND THE CRIMINAL LAW* (1957). See also Annas, *Death and Dying*, CIV. LIB. REV., July 1978, at 71 ("Round-up Book Review").

There is also a growing consensus that the wishes of a previously competent patient, expressed in a document often termed a "living will," should be honored. See, e.g., Bok, *Personal Directions for Care at the End of Life*, 295 NEW ENGLAND J. MED. 367 (1976); Raible, *The Right to Refuse Treatment and Natural Death Legislation*, MEDICOLEGAL NEWS, Fall 1977, at 6; Note, *Informed Consent and the Dying Patient*, 83 YALE L.J. 1632 (1974). Most of the law review articles written on the Quinlan case to date have suggested that many of the problems posed by that case could be alleviated by "living will" legislation. See, e.g., Note, *The Legal Aspects of the Right to Die: Before and After the Quinlan Decision*, 65 KY. L.J. 823, 872-79 (1976-77).

These decisions raise philosophical questions of great importance to persons concerned with "medical ethics." Recently, judges and lawyers have joined the discussion. As of this writing, two state supreme courts have spoken on the problem. In 1976, the Supreme Court of New Jersey decided that the guardian, family, and physicians of Karen Ann Quinlan, a woman in a chronic vegetative state, could disconnect her ventilator and let her die if they agreed that there was "no reasonable possibility" of her ever returning to a "cognitive, sapient state." If a hospital "ethics committee" concurred, all parties involved would be immune from criminal and civil liability.² In late 1977, the Supreme Judicial Court of Massachusetts decided that only a probate court could authorize the nontreatment of Joseph Saikewicz, a 67-year-old mentally retarded terminally ill ward of the state who had leukemia, if there was a treatment available that was used as standard medical practice. The court held that in deciding whether to authorize nontreatment, the probate court should determine what Mr. Saikewicz would have decided had he been able to make the decision himself.³

The *Quinlan* decision has generally been applauded by the medical profession, while the *Saikewicz* opinion has been widely condemned. For example, Arnold S. Relman, M.D., the Editor of *The New England Journal of Medicine*, wrote approximately four months after the Massachusetts decision: "Above all, we must hope that the New Jersey, rather than the Massachusetts, judicial view of this matter will prevail in the rest of the

77) Note, *In Re Quinlan: Defining the Basis for Terminating Life Support Under the Right of Privacy*, 12 TULSA L.J. 150, 164-66 (1976).

² *In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976). This case involved a young woman who, following an episode of unresolved etiology, was in a "chronic persistent vegetative state." While not brain-dead, she had neither cognition nor sapience, and experts believed she could not survive without the aid of a mechanical ventilator. Although the ventilator was removed following the decision of the New Jersey Supreme Court, as of this writing Karen Quinlan continues to live and is being cared for in a New Jersey nursing home.

³ *Superintendent of Belchertown State School v. Saikewicz*, 1977 Mass. Adv. Sh. 2461, 370 N.E.2d 417 (1977). Joseph Saikewicz was a 67-year-old man with an I.Q. of 10 and a mental age of about three years when, on April 19, 1976, he was diagnosed as having acute myeloblastic monocytic leukemia. Chemotherapy is the treatment of choice, and while it causes many unpleasant side effects, there was evidence that it would have afforded him a 30 to 50 percent chance of remission for 2 to 13 months or more. After a hearing, a probate court judge decided, on May 13, 1976, that Mr. Saikewicz would be better off without the treatment, and the Massachusetts Supreme Judicial Court affirmed this decision on July 9, 1976. On September 4, 1976, Mr. Saikewicz died of bronchial pneumonia, a complication of leukemia, apparently without pain or discomfort. The court's opinion, explaining its July 9, 1976 action, was handed down on November 28, 1977. Mr. Saikewicz's retardation was the crucial issue in the case which was complicated by the fact that "there has been no consensus within the [medical profession] on what constitutes appropriate medical intervention in mentally retarded patients with major medical needs." Nelson & Crocker, *The Medical Care of Mentally Retarded Persons in Public Residential Facilities*, 299 NEW ENGLAND J. MED. 1039, 1041 (1978). See Glantz & Swazey, *Decisions Not to Treat: The Saikewicz Case and its Aftermath*, FORUM ON MEDICINE, Jan. 1979, at 22.

country.”⁴ In the Fall 1978 edition of the *American Journal of Law & Medicine*, he continued to lament the *Saikewicz* opinion and to praise the *Quinlan* court as being “generally supportive of long-standing medical tradition.”⁵ That Article did concede, however, that the judiciary has a legitimate role to play in some “very limited and sharply defined cases.”⁶

Understanding the medical reaction to the *Saikewicz* opinion is no easier than understanding the reaction of a patient who is told he or she has a terminal illness. Dr. Elisabeth Kübler-Ross has described the five stages most such patients pass through as denial, anger, despair, bargaining, and acceptance.⁷ Physicians in Massachusetts have evidenced all of the first four stages, many moving along the continuum, and some jumping from an earlier stage to a later one and back again. Denial and anger have been the most common medical responses to *Saikewicz*, with some despair and some bargaining—mainly with the legislature.⁸

Without carrying this analogy too far, I hope that this Article will help Massachusetts physicians to enter and remain in the “acceptance” stage, so far as the *Saikewicz* opinion is concerned. It is my thesis that the dichotomy

⁴ Relman, *The Saikewicz Decision: Judges as Physicians*, 298 NEW ENGLAND J. MED. 508, 509 (1978).

⁵ Relman, *The Saikewicz Decision: A Medical Viewpoint*, 4 AM. J. L. & MED. 233, 234 (1978).

⁶ *Id.* at 241.

⁷ See E. KÜBLER-ROSS, *ON DEATH AND DYING* (1969).

Responding to those who think such issues are exclusively medical, Professor Norman Cantor of Rutgers Law School has noted:

Many physicians and lawyers have asserted that handling of the terminally ill should be left to the medical profession—that the courts have no role in this context. This is a naive position. . . . [Q]uestions of the legality of withholding or withdrawing life-preserving care are constantly lurking in hospitals and would inevitably surface in the courts, whether through homicide, malpractice, or life insurance litigation. The law must eventually fix decision making responsibility and criteria. Courts and/or legislatures cannot duck these issues indefinitely.

Cantor, *Quinlan, Privacy, and the Handling of Incompetent Dying Patients*, 30 RUTGERS L. REV. 243 n.2 (1977).

⁸ In the spring of 1978, the Massachusetts Medical Society and the Massachusetts Hospital Association asked the state legislature to enact a statute that would define death, “legalize” the “living will,” authorize proxy consent to the withholding of treatment for incompetents, and provide immunity for physicians from possible criminal or civil sanctions for making any decisions concerning the dying under the statutory mechanisms suggested. See Carroll, *Who Speaks for Incompetent Patients? The Case of Joseph Saikewicz*, TRUSTEE, Dec. 1978, at 19, 24. The proposed statute was hastily and poorly drafted, suffering from defects that are almost inevitable in such a grab-bag approach to a complex social issue. While pieces of the proposal, like the “living will,” deserve support, the thrust of the proposal was to provide immunity to physicians in an area where it is both inappropriate and unnecessary. The bill was referred to study committee, and is likely to reappear in some form during the 1979 legislative session. As of this writing, the proposed legislation continues to be supported by the Massachusetts Hospital Association, although at a legislative forum on December 15, 1978, the President of the Massachusetts Medical Society, Dr. Russell Rowell, indicated that because of the *Dinnerstein* case, *In re Dinnerstein*, 1978 Mass. App. Adv. Sh. 736, 380 N.E.2d 134 (1978), his organization no longer believed such legislation was necessary.

which most doctors and many lawyers perceive between the *Quinlan* decision and the *Saikewicz* decision is a false one. This Article will suggest to the next court that looks at the question of terminating treatment for an incompetent terminally ill patient that the *Quinlan* and *Saikewicz* cases can be reconciled without being procrustean, and that this reconciliation can simultaneously protect the incompetent patient and permit physicians to exercise sound medical judgment.

The first part of this Article is devoted to reconciling *Quinlan* and *Saikewicz*. The second attempts to explain why these two cases have been so thoroughly confused by the medical profession and some of its legal advisors. Post-*Saikewicz* politics and rhetoric have so distorted these cases in the minds of almost all medical professionals, hospital administrators, and many of their legal advisors, that most have made up their minds about the cases on the basis of misinformation. Some have horribly mistreated their patients, not because they wanted to, but because they believed the *Saikewicz* case compelled them to. The perception by these physicians, by the Massachusetts Medical Society, by the Massachusetts Hospital Association, and by the Editor of *The New England Journal of Medicine*, that *Quinlan* and *Saikewicz* are fundamentally contradictory, can only be understood in light of their political and rhetorical context.

II. RECONCILING QUINLAN AND SAIKEWICZ

The primary task of this Article is to compare the facts and the law of the *Quinlan* and *Saikewicz* opinions to demonstrate that the courts which decided those cases are in fundamental agreement as to both the proper role of the judiciary and the proper role of medical custom in making a decision not to treat a terminally ill incompetent patient. In order to accomplish this goal it is necessary to examine specifically how each court viewed medical custom, the right to privacy, the exercise of this right by an incompetent, and, finally, the role of the judiciary in granting pre-decision immunity.

The main point will be that the *Quinlan* court defined a legally acceptable *medical* standard for decision making which physicians can apply themselves, while the *Saikewicz* court defined a *legal* standard for decision making that only a court can apply. This is the primary difference in the cases, and the one which explains their divergent views on the appropriateness of an "ethics committee."

A. MEDICAL CUSTOM

Both courts viewed customary medical practice (sometimes referred to as "medical ethics") as a critical component in their decision-making process. Their approaches to defining medical custom, however, were

somewhat different. The *Quinlan* court had a more arduous task, since at the trial level there was testimony that removing Karen Quinlan from the ventilator would *not* be consistent with medical ethics.⁹ The court made two points about this. The first was that while medical custom is persuasive authority, it is never controlling, since ultimately only the courts can determine "human values and rights." In the court's words, "Determinations as to these [human values and rights] must, in the ultimate, be responsive not only to the concepts of medicine but also to the common moral judgment of the community at large. In the latter respect the Court has a non-delegable judicial responsibility."¹⁰

The second point the court made was that physicians are too often guided by self-interest or self-protection, which makes custom in regard to the terminally ill patient too conservative. To document this conclusion the court specifically pointed to the "modern proliferation of substantial malpractice litigation and the less frequent but even more unnerving possibility of criminal sanctions. . . ."¹¹ It concluded that a way must be found to enable physicians to make medical judgments free from "possible contamination by self-interest or self-protection concerns which would inhibit their independent medical judgments for the well-being of their dying patients," and added the hope that its opinion would help in this matter.¹²

The *Saikewicz* court did not, like the *Quinlan* court, label physicians self-protectors. It did, however, agree with the *Quinlan* court that while medical ethics are important, they are not controlling. Specifically the *Saikewicz* court said, "While these [medical ethics] considerations are not controlling, they ought to be considered for the insights they give us,"¹³ and later, "Our decision in this case is consistent with the current medical ethos in this area."¹⁴

⁹ See *In re Quinlan*, 137 N.J. Super. 227, 348 A.2d 801 (Ch. Div. 1975). For example, Dr. Sidney Diamond testified that "no physician would interrupt the use of the respirator and that the continued use of the respirator does not deviate from standard medical practice." *Id.* at 247, 348 A.2d at 812. "Dr. Morse [Karen Quinlan's attending physician] . . . refused to concur in the removal of Karen from the respirator. It is his considered position that medical tradition does not justify that act." *Id.* at 259, 348 A.2d at 819.

¹⁰ 70 N.J. at 44, 355 A.2d at 665.

¹¹ *Id.* at 46, 355 A.2d at 666.

¹² *Id.* at 49, 355 A.2d at 668.

¹³ 1977 Mass. Adv. Sh. at 2471, 370 N.E.2d at 423.

¹⁴ *Id.* at 2473, 370 N.E.2d at 424.

The current state of medical ethics in this area is expressed by one commentator who states that: "[W]e should not use *extraordinary* means of prolonging life or its semblance when, after careful consideration, consultation and the application of the most well conceived therapy it becomes apparent that there is *no hope* for the recovery of the patient. Recovery should not be defined simply as the ability to remain alive; it should mean *life without intolerable suffering*."

B. THE RIGHT TO PRIVACY AND SELF-DETERMINATION

Both courts viewed the right to privacy as a constitutional right broad enough to encompass, at least under some circumstances, the right of a competent patient to refuse life-sustaining treatment.¹⁵ The *Quinlan* court identified two state interests that might outweigh this right: the preservation and sanctity of human life, and the integrity of medical decision making. As to the first, the court argued that the "State's interest *contra* weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims."¹⁶ Further discussion by the court, however, makes it appear that the primary emphasis was on prognosis rather than the extent of the bodily invasion. Specifically, just six years prior to this opinion, the court had held in another case that it was appropriate to force a 22-year-old Jehovah's Witness, who had been severely injured in an automobile accident, to have blood transfusions during emergency surgery necessary to save her life.¹⁷ The court distinguished the earlier case, not because a mechanical ventilator is more invasive than blood transfusions during emergency surgery, but primarily because the "patient apparently [was] salvable to long life and vibrant health" as compared to "the instant diametrically opposite case" in which Karen could "only . . . vegetate a few measurable months with no realistic possibility of returning to any semblance of cognitive or sapient life."¹⁸

The *Saikewicz* court identified four potential state interests which might outweigh the competent patient's right to refuse life-sustaining treatment, but found it necessary to discuss at length only the two dealt with by the *Quinlan* court.¹⁹ Again, it is the emphasis rather than the resolution

Id. (quoting Lewis, *Machine Medicine and Its Relation to the Fatally Ill*, 206 J.A.M.A. 387 (1968) (latter emphases added)).

¹⁵ 1977 Mass. Adv. Sh. at 2474-75, 370 N.E.2d at 424; 70 N.J. at 39, 355 A.2d at 663.

¹⁶ *Id.* at 41, 355 A.2d at 664.

¹⁷ *John F. Kennedy Memorial Hosp. v. Heston*, 58 N.J. 576, 279 A.2d 670 (1971). While one could argue that since Heston's family did want the surgery the only added invasion was the blood transfusions, the language of the *Heston* court makes it clear that the court also would have approved of the surgery had consent been withheld. The post-*Roe v. Wade* justification would be the state's interest in preserving life under these circumstances. The pre-*Roe v. Wade* justification that should not survive *Quinlan* was the *Heston* court's finding that "[w]hen the hospital and staff are . . . involuntary hosts and their interests are pitted against the belief of the patient, we think it reasonable to resolve the problem by permitting the hospital and its staff to pursue their functions according to their professional standards." *Id.* at 583, 279 A.2d at 673. See also Note, *The Tragic Choice: Termination of Care for Patients in a Permanent Vegetative State*, 51 N.Y.U.L. REV. 285 (1976).

¹⁸ 70 N.J. at 39, 355 A.2d at 663.

¹⁹ The other two interests identified are the protection of innocent third parties, and the prevention of suicide. The first was not an issue in the case since Mr. Saikewicz had no dependent relatives. Even if he had, one can question whether the interests of third parties should be permitted to overcome an individual's interest in self-determination. The second

that is different. The *Saikewicz* court found that no state interest in the continuation of life can overcome the constitutional right "to decline medical treatment in a situation of incurable illness."²⁰ Since this right is an expression of the sanctity of self-determination, "[t]he value of life as so perceived is lessened not by a decision to refuse treatment, but by the failure to allow a competent human being the right of choice."²¹ The "right to refuse necessary treatment in appropriate circumstances is consistent with existing medical mores";²² and even if it were not, the patient's constitutional rights "are superior to the institutional considerations."²³

Both courts, then, recognized that the right to refuse treatment, even life-sustaining treatment under certain circumstances, is a constitutional right and that this right can be interfered with only if the state can demonstrate a compelling interest. Further, the state's primary interest is in the preservation of life, but this interest diminishes and becomes non-compelling when the prognosis is hopeless (*Saikewicz*) or when there is no

interest, prevention of suicide, was dismissed in a footnote that ended with the following sentences:

Furthermore, the underlying State interest in this area lies in the prevention of irrational self-destruction. What we consider here is a competent, rational decision to refuse treatment when death is inevitable and the treatment offers no hope of cure or preservation of life. There is no connection between the conduct here in issue and any State concern to prevent suicide.

1977 Mass. Adv. Sh. at 2480, 370 N.E.2d at 426 n.11.

An almost identical view of this question was enunciated by the *Quinlan* court: "We would see . . . a real distinction between the self-infliction of deadly harm and a self-determination against artificial life support or radical surgery, for instance, in the face of irreversible, painful and certain imminent death." 70 N.J. at 43, 355 A.2d at 665.

Neither court, however, discussed the societal implications of decreeing suicide an acceptable behavior. See, e.g., Hook, *The Ethics of Suicide*, in *BENEFICENT EUTHANASIA* 57 (M. Kohl ed. 1975). Hook notes that the advocacy of suicide led a French physician, Dr. Binet-Sangle, to suggest, in his *L'Art de Mourir* (1919), the establishment of *un institut d'euthanasie*. More recently, Kurt Vonnegut has suggested that population pressures may make suicide an accepted social behavior, which a government might encourage by establishing "suicide parlors" in which people could voluntarily commit suicide with the aid of an attendant. See K. VONNEGUT, *Welcome to the Monkey House*, in *WELCOME TO THE MONKEY HOUSE* 28 (1970). See also Cantor, *A Patient's Decision to Decline Life-saving Medical Treatment: Bodily Integrity Versus the Preservation of Life*, 26 RUTGERS L. REV. 228 (1973); Delgado, *Euthanasia Reconsidered—The Choice of Death as an Aspect of the Right of Privacy*, 17 ARIZONA L. REV. 474 (1975); Note, *Suicide and the Compulsion of Lifesaving Medical Procedures: An Analysis of the Refusal of Treatment Cases*, 44 BROOKLYN L. REV. 285 (1978).

²⁰ 1977 Mass. Adv. Sh. at 2478, 370 N.E.2d at 426.

²¹ *Id.* Cf.:

Although the Constitution recognizes that human life is, to most persons, of inestimable value and protects its taking without due process of law, nothing in that document compels a person to continue living who does not desire to do so. Such an interpretation effectively converts a right into an obligation. . . .

Delgado, *supra* note 19, at 483.

²² *Id.* at 2480, 370 N.E.2d at 426.

²³ *Id.* at 2481, 370 N.E.2d at 427 (footnote omitted).

reasonable possibility of the patient's returning to a cognitive, sapient state (*Quinlan*). These are extremely important statements about the rights of competent patients, statements that no state supreme court had made previously. The remainder of both decisions deal with the subsidiary, but more sisyphean, question of how this right can be exercised by an incompetent patient.

C. THE INCOMPETENT'S EXERCISE OF THE RIGHT TO REFUSE TREATMENT

For neither court is the right to refuse treatment forfeited by the incompetent. The *Quinlan* court noted that the right is a valuable one which "should not be discarded solely on the basis that her condition prevents her conscious exercise of the choice."²⁴ The *Saikewicz* court made the point even more strongly, declaring that the right extends to the incompetent as well as the competent "because the value of human dignity extends to both."²⁵

Both courts permitted proxies to make the refusal decision for the incompetent patient on the basis of what the proxy believed the incompetent would decide if able to make the decision—that is, on the basis of "substituted judgment." In the *Quinlan* case, the court gave the power to "the guardian and family of Karen to render their best judgment . . . as to whether she would exercise [her right to refuse treatment] in these circumstances."²⁶ But the court went further, and seemed to conclude that almost anyone with Karen's prognosis would refuse treatment, when it noted that if the decision is to terminate life-support measures, "this decision should be accepted by a society the overwhelming majority of whose members would, we think, in similar circumstances, exercise such a choice in the same way for themselves or for those closest to them."²⁷

The analysis by the *Saikewicz* court was corresponding: the test was to determine what Mr. Saikewicz would do if he could make the decision himself. However, as opposed to *Quinlan*, the *Saikewicz* court had to surmount evidence that "most people elect chemotherapy."²⁸ Therefore, the court had to find something unique about Mr. Saikewicz that would enable the lower court to find that he would have refused treatment if he had

²⁴ 70 N.J. at 41, 355 A.2d at 664.

²⁵ 1977 Mass. Adv. Sh. at 2483, 370 N.E.2d at 427.

²⁶ 70 N.J. at 41, 355 A.2d at 664.

²⁷ *Id.* at 41-42, 355 A.2d at 664. This approach has been strongly criticized by the court-appointed guardian of Karen Quinlan who, while agreeing with the outcome of the case, argued that the court had no evidence at all on which to reach this conclusion concerning what the rest of society would do in similar circumstances. Coburn, *In re Quinlan: A Practical View*, 31 ARK. L. REV. 59, 67-69 (1977). See also Corbett & Raciti, *Withholding Life-Prolonging Medical Treatment from the Institutionalized Person—Who Decides?* 3 NEW ENGLAND J. PRISON L. 47, 72-73 (1976).

²⁸ 1977 Mass. Adv. Sh. at 2492, 370 N.E.2d at 431.

had the chance. One possibility was the fact that Mr. Saikewicz was severely retarded. The court, however, rejected this as the sole rationale on the basis that "quality of life" could not be the determining factor. Nonetheless, the court used Mr. Saikewicz's retardation against him indirectly by finding that, when coupled with the negative factors that competent persons tend to weigh less heavily in the chemotherapy treatment decision (age, probable side effects, low probability of remission, certain suffering), the fact that Mr. Saikewicz would be unable to understand and cooperate with the treatment justified the conclusion that he would have refused it. In the court's words:²⁹

He . . . would experience fear without the understanding from which other patients draw strength. The inability to anticipate and prepare for the severe side effects of the drugs leaves room only for confusion and disorientation. The possibility that such a naturally uncooperative patient would have to be physically restrained to allow the slow intravenous administration of drugs could only compound his pain and fear, as well as possibly jeopardize the ability of his body to withstand the toxic effects of the drugs.

It should be noted that while both courts adopted the subjective "substituted judgment" test in which the guardian or court is asked to determine what the incompetent would do if able to decide, there was almost no basis on which either court could determine the actual desires of the two incompetents involved. Karen had not signed a living will, and had discussed her situation only hypothetically under circumstances that the lower court found insufficient to justify conclusions as to her actual wishes. Mr. Saikewicz, with a mental age of less than three years, never was personally able to formulate any decisions on such questions. Therefore, while the doctrine of "substituted judgment" makes most sense from the viewpoint of protecting the right to privacy and self-determination of the incompetent, in the two cases under discussion, use of the more objective "best interests" test would have been more logical.³⁰

²⁹ *Id.* at 2494, 370 N.E.2d at 432. All this, of course, is just another way of saying that chemotherapy should not be used on retarded individuals where the probability of success is limited. The court could have avoided this result by adopting the test of judicial review used by Justice Quirico in *Nathan v. Farinelli*, Mass. Suffolk Eq. 74-87 (1974), who found the only logical test in a similar circumstance of proxy consent was whether the decision was "fair and reasonable" under the circumstances.

³⁰ While an argument can be made that Karen's parents were in a position to determine what decision she would make, Paul Ramsey argues persuasively that the *Saikewicz* court projected "the unknowable into the unknown" and must be viewed as substituting its subjectivity for Mr. Saikewicz's. Ramsey, *The Saikewicz Precedent: What's Good for an Incompetent Patient?* HASTINGS CENTER REP., Dec. 1978, at 36, 39.

That the Massachusetts Supreme Judicial Court has made no final determination on the proper standard is clear from its post-*Saikewicz* decision ordering (against the wishes of the

D. IMMUNITY: MEDICAL VERSUS SOCIETAL DECISIONS

Thus far, the analysis has described the law of the two cases as identical in most respects. This section will attempt to demonstrate that it was the particular facts of each case and the tests adopted to decide them which prompted the seemingly divergent resolutions, and that the courts agree with each other much more fundamentally than the *Saikewicz* court explicitly acknowledges.

The *Quinlan* court viewed medical prognosis as the key to unfettered exercise of a right to refuse treatment in Karen Quinlan's case, and it viewed its job as finding a way to get physicians to do the "right" thing without worrying about self-protection. Believing that its solution to this self-imposed problem was to create a quasi-administrative agency with the authority to grant civil and criminal immunity in a narrow range of cases decided on the basis of medical prognosis, the court adopted the "ethics committee" approach recommended by pediatrician Karen Teel, as a method of taking the liability burden off physicians by "diffus[ing] the responsibility for making these judgments."³¹ It also rejected any requirement of routine court proceedings in cases like that of Karen Quinlan because it viewed such a requirement as a "gratuitous encroachment upon the medical profession's field of competence" and as "impossibly cumbersome."³²

parents) chemotherapy for a two-year-old boy with a reasonable chance of cure. *In re Custody of a Minor*, 1978 Mass. Adv. Sh. 2002, 2031-34, 379 N.E.2d 1053, 1065-66 (1978). See also Baron, Botsford, & Cole, *Live Organ and Tissue Transplants from Minor Donors in Massachusetts*, 55 B.U.L. REV. 159 (1975). Probably the primary reason for adopting the "substituted judgment" over the "best interests" test in both cases was that very good arguments can be mustered to demonstrate that continued treatment was actually in the best interests of both Karen Quinlan and Joseph Saikewicz. To the extent that this is true, it is another example of the old adage that "hard cases make bad law." For a discussion of the doctrine of "substituted judgment," see Robertson, *Organ Donations by Incompetents and the Substituted Judgment Doctrine*, 76 COLUM. L. REV. 48 (1976).

³¹ 70 N.J. at 49, 355 A.2d at 669 (quoting Teel, *The Physician's Dilemma: A Doctor's View: What the Law Should Be*, 27 BAYLOR L. REV. 6, 8-9 (1975)). Note that the court made no independent determination of who should sit on such a committee, how they should be appointed, or how they should proceed. Instead it relied entirely on a quotation from Dr. Teel's article, which said in relevant part: "Many hospitals have established an Ethics Committee composed of physicians, social workers, attorneys, and theologians, . . . which serves to review the individual circumstances of ethical dilemma and which has provided much in the way of assistance and safeguards for patients and their medical caretakers." 70 N.J. at 49, 355 A.2d at 668 (quoting Teel, *supra*, at 8-9). It should also be pointed out that Dr. Teel's "article" is actually a four-page speech and her suggestions were not the result of any elaborate comparison of alternatives. The court reveals its knowledge of this by its use of ellipses in the above quotation to replace the words "(known irreverently in some circles as the 'God Squad')." None of my remarks are meant to reflect on Dr. Teel, who acknowledges at the beginning of her speech that she has no credentials in "medical ethics, forensic medicine, [or] theology," but is speaking from "the perspective of a single practicing pediatrician who cares for infants and children and their families." *Id.* at 6.

³² 70 N.J. at 50, 355 A.2d at 9.

On the surface, it appears, as it did to the *Saikewicz* court, that the *Quinlan* court was engaged in a wholesale delegation of judicial authority to local, ad hoc administrative agencies called ethics committees. This is certainly one possible interpretation. It is more reasonable, however, to read the decision as one which simply told physicians that when they are making treatment decisions on the basis of *medical* criteria, they should not be worried about immunity. If they are worried, calling in a consultant, here termed an "ethics committee," should relieve them of this fear.

Specifically the *Quinlan* court permitted the "ethics committee" to grant immunity only after Karen's guardian, family, and attending physicians concluded that there was "no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, sapient state."³³ The ethics committee then, and only then, could be consulted and asked to concur in this narrow prognosis determination.³⁴ It must be

³³ *Id.* at 54, 355 A.2d at 671.

³⁴ *Id.* It cannot be overemphasized that the issue for the New Jersey court was one of prognosis: "The evidence in this case convinces us that the focal point of decision should be the prognosis as to the reasonable possibility of return to cognitive and sapient life, as distinguished from the forced continuance of that biological vegetative existence to which Karen seems to be doomed." *Id.* at 51, 355 A.2d at 669. The holding is precise:

Upon the concurrence of the guardian and family of Karen, should the responsible attending physicians conclude that there is *no reasonable possibility* of Karen's ever emerging from her present comatose condition to a *cognitive, sapient state* and that the life-support apparatus now being administered to Karen should be discontinued, *they shall consult with the hospital "Ethics Committee"* or like body of the institution in which Karen is then hospitalized. If that consultative body agrees that there is no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, sapient state, the present life-support system may be withdrawn and *said action shall be without any civil or criminal liability therefor on the part of any participant, whether guardian, physician, hospital or others.*

Id. at 54, 355 A.2d at 671 (emphasis added; footnote omitted). In other words, the *only* benefit received from going to an "ethics committee" is what the physicians wanted: legal immunity. Since the only relevant legal issue is prognosis, one obtains no ethical insights, only legal comfort. It is the Massachusetts Supreme Judicial Court's refusal to permit such "rubber stamp," nonjudicial granting of legal immunity that has so upset the Massachusetts hospital and medical community. In almost every other respect, the *Quinlan* decision, which Relman endorses, and the *Saikewicz* decision are identical. See Annas, *In re Quinlan: Legal Comfort for Doctors*, HASTINGS CENTER REPORT, June 1976, at 29.

New Jersey, however, understandably remains confused over the proper role of such a committee. At the Morris View Nursing Home, for example, where Karen Quinlan is currently a patient, an ethics committee was formed when the nursing home knew she would be coming there. It consists of a physician, an attorney, two clergymen, a social worker, and the chairman, who is also Chairman of the Morris County Welfare Board, which manages the nursing home. This committee apparently sees itself not as a "prognosis committee" but as a committee to deal with "ethical issues." This view may account for the fact that to date the committee, while it has met, has never decided anything and has not yet even devised a method for reaching a decision. Esqueda, *Hospital Ethics Committee: Four Case Studies*, THE HOSPITAL MEDICAL STAFF, Nov. 1978, at 26, 26-27. Nevertheless, the ethics committee approach has not been without defenders. See, e.g., Note, *In re Quinlan: One Court's Answer to the Problem of Death with Dignity*, 34 WASH. & LEE L. REV. 285, 305-07 (1977).

emphasized that while the term "ethics committee" was used by the court, a more accurate description would be "prognosis committee," because that is the *only* issue on which the participants would be asked to consult.³⁵ Further, since non-medical professionals have no expertise on this issue, the opinion would be more consistent if it simply required the concurrence of one or more medical experts in the prognosis determination.

While no judicial body should abdicate its responsibility to determine ultimately what is legal and illegal, the *Quinlan* decision can be read as simply affirming the general laws of malpractice and negligent homicide; that is, if the physician's decision is challenged in a civil or criminal proceeding, he or she will be judged on whether or not his or her conduct was consistent with custom or "accepted medical practice,"³⁶ a determination made by a judge or jury only after hearing expert testimony from other physicians on the proper standard of care. Assuming that such experts have been consulted initially, and have agreed in writing that the physician's proposed action is consistent with "accepted medical practice," no liability is likely ever to obtain.³⁷ Therefore, if one accepts the premise that the *Quinlan* criteria are fundamentally a matter of medical prognosis, then the court's "immunity doctrine" can be viewed simply as a restatement

³⁵ Apparently in recognition of this, the New Jersey attorney general's guidelines for setting up such committees describe them as "prognosis committees." See Hirsch & Donovan, *The Right to Die: Medico-Legal Implications of In re Quinlan*, 30 RUTGERS L. REV. 267, 286 (1977).

³⁶ See HARPER & JAMES, *THE LAW OF TORTS*, § 17.3, at 977 (1956); WALTZ & INBAU, *MEDICAL JURISPRUDENCE*, Ch. 4, at 38 (1971); Morris, *Custom and Negligence*, 42 COLUM. L. REV. 1147, 1163-68 (1942). There are a handful of exceptions to this general rule, most based on *The T. J. Hooper*, 60 F.2d 737 (2d Cir. 1932), but these cases only tend to prove the general rule, and also demonstrate that ultimately courts must decide what the proper standard should be if innocent third parties are to be protected. See, e.g., *Helling v. Carey*, 83 Wash. 2d 514, 519 P.2d 981 (1974) (physicians liable for not performing glaucoma test on young woman who subsequently went blind, even though such testing was not standard medical treatment, because the test was accurate, simple, inexpensive, safe, and detected a serious, arrestable condition). On this case see Note, *Comparative Approaches to Liability for Medical Maloccurrences*, 84 YALE L.J. 1141 (1975).

³⁷ See, e.g., Robertson, *Involuntary Euthanasia of Defective Newborns: A Legal Analysis*, 27 STAN. L. REV. 213 (1975); *Commonwealth v. Edelin*, 1976 Mass. Adv. Sh. 2795, 359 N.E.2d 4 (1976); and the following language in the *Quinlan* opinion:

Under the statutes of this State, the unlawful killing of another human being is criminal homicide. . . . [But] we believe, first, that the ensuing death would not be homicide but rather expiration from existing natural causes. Secondly, even if it were to be regarded as homicide, it would not be unlawful.

These conclusions rest upon definitional and constitutional bases. The termination of treatment pursuant to the right of privacy is, within the limitations of this case, *ipso facto* lawful. . . . There is a real, and in this case, determinative distinction between the unlawful taking of the life of another and the ending of artificial life-support systems as a matter of self-determination.

70 N.J. at 51-52, 355 A.2d at 669-70 (1976). See also Note, *The Termination of Life-Support Measures and the Law of Murder*, 41 MODERN L. REV. 423 (1978).

of the law, intended to encourage physicians to fulfill their professional obligations without undue fear of lawsuits.

Interpreted in this way the opinion is sound, and future opinions need only refine the role of the medical consultant or committee by removing the label "ethics committee" and replacing it with a phrase like "qualified medical specialist," or "prognosis committee."

The *Quinlan* court, in summary, viewed the decision concerning continued mechanical ventilation of Karen Quinlan as one that could be based solely on medical prognosis. Since medical prognosis is primarily and most often exclusively determined by physicians, the court found no reason why decisions made on this basis should come to court. To prevent additional cases of this type from coming to court, the court set up an alternative method for physicians to receive "immunity," if they felt they needed it.

It was, of course, the *Quinlan* court's establishment of this alternate, nonjudicial method of gaining immunity that so disturbed the *Saikewicz* court. One must recall, however, that the facts of these two cases differed in critical respects. The *Quinlan* court had to decide whether to overrule a lower court decision in order to permit attending physicians to discontinue mechanical ventilation of a woman who was still alive at the time the opinion was written; the *Saikewicz* court was faced with writing an opinion rationalizing a prior decision it had made against treatment of a mentally retarded cancer victim who, by the time the opinion actually was written, had been dead for more than a year.³⁸ In addition, Mr. Saikewicz did not

³⁸ Mr. Saikewicz died, apparently peacefully, within three months of the original court decision to permit the withholding of chemotherapy, but more than a year before the supreme judicial court issued its opinion justifying this action. There was never a full adjudicatory hearing on the issue of treating Mr. Saikewicz, and all lawyers and physicians who appeared before the lower court argued against treatment. If an attorney had been appointed to argue that treatment was indicated, it seems likely that treatment would have been ordered. On the lower court proceedings, see Kindregan, *The Court as Forum For Life and Death Decisions: Reflections on Procedures for Substituted Consent*, 11 SUFFOLK U. L. REV. 919 (1977).

The testimony supports such a conclusion; it was inexact and was based entirely on the opinions of the physicians involved. The same physician who testified that remissions vary from "two months to thirteen months," for example, also testified that they occur in "forty to fifty percent of treatments," *In re Saikewicz*, No. 45596, Transcript of Proceedings 15 (Mass. Probate Court, Hampshire County May 13, 1976), and that "If we give him the chemotherapy, he will become very sick and if we treat him intensively, then he *might live indefinitely and recover*. Q. You say that he might live indefinitely? A. I am saying for a year or so." *Id.* at 22 (emphasis added). Another physician, who put the probability of a remission at 30 percent, testified, "We gave a great deal of thought to whether he should be treated because it wasn't a straight forward issue. One issue certainly had to be, what was the *quality of his life as we saw it* and how we'd influence this one factor. . . ." *Id.* at 24-25 (emphasis added). Near the close of the testimony, the judge made this observation:

I had a patient, a patient at the State Hospital who didn't want water, and didn't want food. So the doctors were frightened for without water and without food he would die. They had a hearing such as this and they were asking the Court his permission to allow them to force feed this patient. This must have been about two

meet the *Quinlan* criterion in that he was both cognitive and sapient. Accordingly, a decision in *Saikewicz* could not be based on the *Quinlan* prognosis criterion. As the court stressed in *Saikewicz*, the decision had to be based on a determination involving "substituted judgment," a legal rather than a medical standard.

It was this difference in decision criteria that led the *Saikewicz* court to resoundingly reject the *Quinlan* "ethics committee" approach. Its rejection was based on the premise (which I believe was mistaken) that the *Quinlan* court had permitted the "ethics committee" to make legal or judicial decisions rather than simply to act as a medical consultant on the issue of prognosis. Viewed in the former light, the delegation of judicial authority can be seen as both unprecedented and dangerous to the rights of the incompetent. Since this is how the *Saikewicz* court did view the matter, it condemned such a mechanism, noting that it took "a dim view of any attempt to shift the ultimate decision-making responsibility away from the duly established courts of proper jurisdiction to any committee, panel or group, ad hoc or permanent."³⁹ It was after this rejection that the court commented that "judicial resolution" of the question is appropriate and cannot be construed as a "'gratuitous encroachment' on the domain of medical expertise."⁴⁰ Then followed the sentences many physicians have interpreted as a slap in the face:⁴¹

[S]uch questions of life and death seem to us to require the process of detached but passionate investigation and decision that forms the ideal on which the judicial branch of government was created. Achieving this ideal is our responsibility and that of the lower court, and is not to be entrusted to any other group purporting to represent the "morality and conscience of our society," no matter how highly motivated or impressively constituted.

The court takes this view, it seems to me, because the issue in *Saikewicz* was not one of medical prognosis—the court accepted the probate court's finding that the proposed treatment offered a reasonable chance of a remission of from 2 to 13 months or more⁴²—but a legal question of

years ago and the patient is living because they did force feed and gave him water and food by force and he is still alive and happy. In effect, they saved his life or that saved his life. This is a similar type of case, in a way.

Id. at 29. Again, at the close of the testimony, the judge said: "I am inclined to give treatment." *Id.* at 31. Only unanimous and vigorous objection changed his mind. *Id.* at 33. See Baron, Assuring "Detached but Passionate Investigation and Decision": The Role of Guardians Ad Litem in *Saikewicz*-type Cases, 4 AM. J. L. & MED. 111, 120-22 (1978).

³⁹ 1977 Mass. Adv. Sh. at 2499, 370 N.E.2d at 434.

⁴⁰ *Id.* at 2501, 370 N.E.2d at 435.

⁴¹ *Id.*

⁴² *Id.* at 2468, 370 N.E.2d at 421.

"substituted judgment." This latter question has always been a matter for the courts, and is an issue on which physicians have no expertise at all.⁴³ As to the "ultimate" question of immunity, the *Saikewicz* court believed that only a court should make such decisions and that to permit any other agency to make them would be an improper delegation of judicial authority.

E. SUMMARY

In short, as previously suggested, the decisions can be reconciled. *Quinlan* based its final conclusion on the use of a prognosis criterion that is medical. While the court approved the "substituted judgment" test, it found it unnecessary, because it thought almost everyone with Karen's prognosis would refuse treatment if they could. Since the court believed physicians were refusing to exercise their best medical judgment for fear of civil and criminal liability, it set up an informal mechanism by which physicians can be guaranteed immunity before the fact without having to resort to the courts. This mechanism was seen as appropriate both because it is relatively speedy and because the only thing that would happen in court in any event is that medical experts would be asked to testify about the accuracy of the prognosis. The court believed that such determinations are best left in the hospitals, and that its decision would accomplish this end.

The issue in the *Saikewicz* case, on the other hand, was much more complex. It was not a question of medical prognosis, but of whether to use an accepted medical treatment on a mentally retarded individual whose life could be sustained for an indefinite period of time. The court determined that such a question can only be answered on the basis of "substituted judgment," and since this is a legal standard, a court hearing is required. Further, since the issues are complex and the decision irrevoc-

⁴³ An alternative way to state the issue from the physician's point of view is: "Can I discontinue treatment without fear of liability for medical malpractice or homicide?" Stated this way, the role of the courts is even clearer, since courts ultimately set and apply the standards for both negligence and criminal liability. No one would think it strange to ask a court whether doing "X" was either a negligent or a criminal act. In essence, it is this question that both courts are being asked. One is able to answer it on the basis of medical prognosis, the other is not.

An analogous differentiation has been made in the literature concerning the insanity defense. Expert witnesses are generally permitted to testify on what are termed "medical facts" (for example: Did the defendant suffer from a mental disease or disorder? Was he capable of knowing right from wrong?), but not on the ultimate issue of responsibility, which is generally characterized as a "legal standard" to be decided only by the jury. See, e.g., A. GOLDSTEIN, *THE INSANITY DEFENSE* 97-101 (1967).

Where, as in *Quinlan*, the "medical facts" are determinative and uncontested, there is arguably no need for any judicial review, since the "medical facts" have been formally adopted as a "legal standard" themselves.

able, the court suggested that such a hearing should be adversary in nature, with arguments presented to the court on both sides of the issue.⁴⁴ Only after such a hearing can the ultimate legal question of immunity be answered.

Stated another way, when a patient's condition is "hopeless," or when he or she has "no reasonable possibility of returning to a cognitive, sapient state," the state can *never* demonstrate an interest compelling enough to outweigh the patient's constitutional right to refuse treatment as exercised by a legal guardian. Therefore, there is no reason to require that the legal

⁴⁴ Professor Charles Baron of Boston College Law School urges the court to insist that a true adversary proceeding take place. Baron, *Assuring "Detached but Passionate Investigation and Decision": The Role of Guardians Ad Litem in Saikewicz-type Cases*, 4 AM. J. L. & MED. 111 (1978).

The importance of such a judicial hearing is well illustrated by Dr. Relman's assertions about Kerri Ann McNulty. He describes her as a child "born with congenital rubella (German measles) found to be blind, deaf, and seriously mentally defective." Relman, *supra* note 5, at 238. Relman describes this case as "distressing" and an "unhappy example of the *Saikewicz* decision." *Id.* at 239.

This case illustrates a type of "eugenic" abuse that may be taking place frequently in the hospitals of Massachusetts. The "medical facts" of the case turned out to be much different than initially characterized. After a full hearing, Judge Henry R. Mayo concluded: "[T]he child has serious medical problems including cataracts on both eyes and perhaps additional eye complications. She appears to be deaf. . . . It is *highly probable* that she has *some degree* of mental retardation, the extent of which cannot yet be determined. . . . [S]he can survive if properly treated. *In re McNulty*, No. 1960, Findings of Fact 3-4 (Mass. Probate Court, Essex County Div. Feb. 15, 1978) (emphasis added). In other words, "blind, deaf, and seriously mentally retarded" are conclusions all of which are at least premature, if not inaccurate. Under such circumstances, how can it ever be in a child's "best interests" to die rather than to live? And the idea of accurately testing the mental ability of an infant who cannot see or hear is ludicrous on its face. Even if such a measurement could be made, however, the decision whether to treat is still a societal rather than a medical one. In this regard the *Saikewicz* decision is clear; it calls for court review anytime one proposes to withhold a standard medical treatment that is potentially life-sustaining from an incompetent under circumstances where a competent patient might choose the treatment. In view of the potential abuses without such review, the remedy does not seem extraordinary. Since there is no crime of not going to court, the remedy is not automatic, and most physicians are likely to continue to make decisions knowing that they may someday face criminal or civil charges as a result (the probability of both being very low), rather than seek a declaratory judgment of the type approved in *Saikewicz*.

Some physicians and lawyers have argued that physicians are worse off if they don't go to court after *Saikewicz*, since the fact that they did not avail themselves of the declaratory judgment route suggested by the court may itself be used as evidence against them in a civil or criminal case. The argument, I take it, is that they must have been acting in "bad faith" or had something to hide, since if their actions were ethically sound, they would have gone to court. The answer, I think, is that so long as they fully document the reason for their decision, and call in an appropriate consultant on the medical prognosis issue, the allegation of bad faith can be easily rebutted by demonstrating that all actions were done openly and in accordance with good and accepted medical practice. In this regard, documentation of all orders, both in the patient's progress notes and in the physician's order sheet, signed by the physician and including an explanation for the order given, is recommended. Cf. *Standards for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiac Care (ECC)*, 227 J.A.M.A. (Supp.) 833, 864 (1974).

guardian seek court approval before exercising the incompetent's right to refuse treatment, especially if the courts believe all or almost all persons so situated would refuse treatment if they could. Likewise, if there is a reasonable chance that the patient will return to normalcy, and the case is an emergency, treatment should always be started, because of the state's compelling interest in the preservation of life, without any resort to the courts. It is the cases between these extremes for which neither court offers much guidance.

To conclude that the opinions can be reconciled is not to say that one always can predict how courts will rule in individual cases. For example, should someone bring a case like that of *Quinlan* to court in Massachusetts, a probate court could require continued treatment on the basis that her condition is not "hopeless," she is not suffering, and therefore she would want treatment continued. Also, had the *Saikewicz* case been brought in New Jersey, that supreme court might well have decided that treatment should be required in order to promote the state's interest in life, because *Saikewicz* could be maintained in a cognitive, sapient state. Thus, the focus is not (and should not be) on whether the *Quinlan* and *Saikewicz* courts made the "right" decision concerning treatment, but on whether the procedures and criteria applied in reaching the decisions are likely to be equitable, fair, and prudent when applied to future cases.

Both courts support physicians in their independent exercise of medical judgment. Both courts support patients in their exercise of self-determination in refusing treatment and concur that incompetents have this right as well. Under the facts in *Quinlan*, the decision whether to terminate treatment could appropriately be based on medical criteria alone, so the court devised a mechanism to keep such decisions out of the courts. Under the facts in *Saikewicz*, the medical criteria were not controlling, so a legal determination had to be made. Both courts would agree, I submit, that medical decisions should be made by physicians following accepted medical practices, and that legal or social decisions should be made by courts.

This conclusion is necessary not because judges and lawyers are more intelligent than physicians, but because judges have the social mandate to distill the values and morals of society on which most of these cases must ultimately be decided. In the words of Justice Benjamin N. Cardozo:⁴⁵

You may say that there is no assurance that judges will interpret the mores of their day more wisely and truly than other men. I am not disposed to deny this, but in my view it is quite beside the point. The point is rather that this power of interpretation must be lodged somewhere, and the custom of the constitution has

⁴⁵ B. CARDOZO, THE NATURE OF THE JUDICIAL PROCESS 135-36 (1921). See also Baron, *Medical Paternalism and the Rule of Law: A Response to Dr. Relman*, 4 AM. J. L. & MED. 337 (1979).

lodged it in the judges. If they are to fulfill their function as judges, it could hardly be lodged elsewhere. Their conclusions must, indeed, be subject to constant testing and retesting, revision and readjustment; but if they act with conscience and intelligence, they ought to attain in their conclusions a fair average of truth and wisdom.

III. WHY QUINLAN AND SAIKEWICZ ARE VIEWED AS CONFLICTING DECISIONS

If the arguments presented above are accepted, one must ask why the medical community has viewed *Quinlan* and *Saikewicz* as conflicting, and why so much energy has gone into attempting to get the *Saikewicz* decision legislatively or judicially changed in favor of a so-called *Quinlan* approach. The initial answer, implicit in the preceding discussion, is that neither the *Quinlan* nor the *Saikewicz* court is completely logical or clear. The *Quinlan* court, for example, quoting from an article by a physician, described an "ethics committee" that is far different from the one needed to answer the narrow question that the court delegates to it. The court gave no other guidance, such as who appoints the committee, when it meets, who calls the meeting, how and if it votes, what a quorum or majority is, who the chairman is, whether the incompetent gets represented, or what the notice requirements are. The resulting confusion concerning the role of this committee is therefore understandable.⁴⁶

Likewise, the *Saikewicz* court arguably misunderstood what the *Quinlan* court intended as the proper role of such an ethics committee, and as a result reacted so strongly against it that its opinion has been read by some as a blanket condemnation of any medical decision making in cases involving terminally ill patients. While I do not agree with such an interpretation of *Saikewicz*, it is certainly one that can be made by counsel who have not spent a good deal of time studying the cases on which the court rests its decision, and it is one for which the court must take some of the blame.

Few judicial decisions are flawless, however, and it is the responsibility of lawyers to interpret decisions in reasonable ways, not in ways that assume the court does not know what it is doing. A review of some of the medicolegal advice given in Massachusetts concerning *Saikewicz* illustrates many of the inherent problems in interpreting these decisions and the limitations of the legal resources currently available to physicians and hospitals in Massachusetts. It is conceded at the outset that much of the

⁴⁶ See note 34 *supra*. For a more detailed discussion of the "ethics committee" and the problems it poses, see Colleser, *Death, Dying and the Law: A Prosecutorial View of the Quinlan Case*, 30 RUTGERS L. REV. 304, 319-21 (1977); Hirsch & Donovan, *The Right to Die: Medico-Legal Implications of In re Quinlan*, 30 RUTGERS L. REV. 267, 273-74, 280-86 (1977).

evidence is anecdotal, but until a formal study is done, it is the best available.

The medical profession's lack of familiarity with legal reality was dramatically illustrated nationally during the so-called "malpractice insurance crisis" of 1974 and 1975, which was commonly viewed as a reflection of unfair legal rules rather than substandard medical practice.⁴⁷ The aftermath of the *Saikewicz* case exposes the problem on a local level. On March 2, 1978, the legal columnist of *The New England Journal of Medicine* wrote that physicians and news reporters were correct in concluding that in *Saikewicz*, the Massachusetts Supreme Judicial Court "really did mean that all decisions on either removal of life-support systems or continuation of life-extending therapy in otherwise dying patients who are incompetent . . . must go before a Probate Court for approval."⁴⁸ With this encouragement, Dr. Relman wrote an accompanying editorial which concluded that the justices had a "total distrust of physicians' judgments" and that their "astonishing opinion can only be viewed as a resounding vote of 'no confidence' in the ability of physicians and families to act in the best interests of the incapable patient suffering from a terminal illness." As

⁴⁷ See S. LAW & S. POLAN, *PAIN AND PROFIT: THE POLITICS OF MALPRACTICE* (1978). The authors note that many states have made changes in their laws relating to medical malpractice as a result of heavy lobbying efforts by the medical profession and malpractice insurance companies. *Id.* at 100. They believe two reasons account for the popularity of such changes: (1) physicians and insurance companies wanted them badly and plaintiffs' lawyers, "who had the most accurate understanding of the practical effects, knew that such changes would not make any significant difference," *id.* at 119; and (2) "reforms which can be accomplished by changing the words of a law . . . are always easier to effect than reforms which require the expenditure of public funds or the creation of an agency to administer them." *Id.* The authors conclude: "[R]evising a legal rule is easy. In this case, it is not likely to help." *Id.*

⁴⁸ Curran, *Law-Medicine Notes: The Saikewicz Decision*, 298 NEW ENGLAND J. MED. 499 (1978). Professor Curran reaffirmed his views in a reply to letters addressing his initial column:

The courts have never before been so universally intrusive as to demand that *every decision either to continue or not to continue* life-sustaining medical efforts in mentally incompetent persons must go to court for determination. . . .

. . . The issue is clear. The Supreme Judicial Court does not trust any part of the private community except the probate court to decide these matters.

298 NEW ENGLAND J. MED. 1209 (1978) (emphasis added). While the distinction between removal and continuance of treatment is literally true, the decision to continue treatment is trivial insofar as potential liability goes, since the suit would not be for negligence or homicide, but would allege a battery. The physician's defense would be privilege, that is, that he was doing his best to save the patient's life, and the likelihood that he would lose such a suit, so long as he was acting in good faith, approaches zero.

It is, however, possible that some day there will be a successful battery suit by the patient's guardian or the administrator of his or her estate against a physician who continued treatment even though the patient had signed a living will and the patient's guardian had demanded that treatment be halted. A successful suit of this type might be more effective than legislation in encouraging physicians to take "living wills" seriously.

previously noted, Relman urged judges in other jurisdictions to adopt the *Quinlan* approach instead, and suggested additionally that all those who did not agree with him take a "guided visit to a large acute-care hospital."⁴⁹

In the weeks immediately following the publication of these pieces, my colleague Leonard Glantz and I, both of us then with Boston University's Center for Law and Health Sciences, discussed the *Saikewicz* case with a number of physicians. More than once we were told that while we were entitled to our own view of the law, the physician had read *The New England Journal of Medicine* and therefore knew that no action could be taken regarding an incompetent terminally ill patient without an order from the probate court. In one instance, I spoke a number of times with the physician attending a patient who had suffered a massive stroke. I had convinced the physician, who believed his patient's condition was completely hopeless and death was imminent, that he was not legally obligated to resuscitate the patient repeatedly. He called me later and said he had consulted the hospital administrator, who demanded that his patient remain in the intensive care unit until the family took the case to court. I have since learned that the patient was so maintained for an additional four weeks, and finally died the day after a legal aid attorney submitted a petition to the probate court.⁵⁰

Other cases have since been reported, which include a Tay-Sachs baby being repeatedly resuscitated; a Werdnig-Hoffmann's syndrome child being heroically maintained; a dying woman being defibrillated 70 times in a 24-hour period; and a brain-dead individual for whom the implantation of a cardiac pacemaker was being planned—all at the urging of hospital counsel.⁵¹ At medicolegal conferences on the *Saikewicz* case, nurses told of family members barring the patient's door to prevent resuscitation of dying loved ones in hospitals whose counsel had advised them that *Saikewicz* had outlawed "no-code" orders.⁵² It appears that many lawyers advising Massachusetts hospitals on the law of the *Saikewicz* case lack ex-

⁴⁹ See Relman, *supra* note 4, at 508-09.

⁵⁰ This happened at a major Boston hospital during a time when the patient's care was covered by Medicaid and the intensive care unit was not full. Needless to say, hospital administrators have an economic conflict of interest in such decisions, and should generally have nothing to say about maintaining "hopeless" patients against the wishes of the family and attending physician. Cf. Note, *Euthanasia: The Physician's Liability*, 10 J. MAR. J. PRAC. & PROC. 148 (1976).

⁵¹ The Tay-Sachs case was reported to me by a nurse involved in the care of the infant; the Werdnig-Hoffmann's case was written up in the Boston Phoenix, May 23, 1978, at 6-7, and featured on the NBC Today Show on November 16, 1978; the defibrillation case was recounted at a meeting of the alumni of Boston University's Health Care Management Program on May 23, 1978; the pacemaker case was recounted by an attorney who was called in by a medical resident in the hospital for independent legal advice.

⁵² One such conference was sponsored by the Committee on Disabilities and Health Law of the Personal and Probate Section of the Massachusetts Bar Association at the Harvard School of Public Health on May 13, 1978.

perience and training in health law and have little familiarity with either medical practice or hospital procedures.⁵³ This has resulted in the types

⁵³ While this is a harsh verdict, it is justified by the available evidence. For example, on April 10, 1978, the Newton-Wellesley Hospital adopted as policy the interpretation and suggestions concerning the *Saikewicz* case made by the Boston firm of Ropes & Gray. The hospital's executive director, William C. Christenson, in a cover memorandum addressed to each staff physician, wrote: "We must regretfully advise you that as of April 18, 1978, the Newton-Wellesley Hospital will comply with the law under the so-called 'Saikewicz Decision'." The memorandum later stated: "We deplore the Court's intrusion into an area which has always been highly private and deeply personal. Historically, the decision has been quietly and compassionately made by the patient and/or family and the physician. Now, the Court has established a cumbersome and expensive procedure which attracts notoriety."

Attached to this memorandum was another directed to the Management Council, Nursing Supervisors, and Head Nurses, and a copy of the hospital legal counsel's interpretation of the *Saikewicz* opinion. Memorandum, Inability or Refusal of Patient to Consent to Life-Saving or Life-Prolonging Treatment. While granting that "the possibility of a doctor or nurse being prosecuted and convicted for withholding life-prolonging treatment, based on prior experience, seems remote," *id.* at 1, the attorney's memo explained how liability could be avoided with certainty. The memorandum first discussed the competent patient: "Perhaps the clearest situation is that a competent patient cannot refuse life-prolonging treatment if she is pregnant and the refusal of treatment will adversely affect the fetus." *Id.* at 2. When asked by Leonard Glantz whether the writers of this memo had considered the implications of *Roe v. Wade* on this issue, a member of the firm replied that they had not.

As to who can be considered a "competent patient," the memo suggested that ability "to comprehend the English language" is a prerequisite, as is the lack of "evidence of prior institutionalization for mental problems." No general definition of competence was suggested. *Id.* at 3.

The memorandum summarized the *Saikewicz* case as saying that "Court approval is necessary . . . to withhold treatment when the patient needing medical attention is 'incompetent'." *Id.* at 3. The memo then argued that "[i]t is not clear whether the *Saikewicz* procedures apply where a patient is incompetent because he has experienced brain death." *Id.* at 4. This is, of course, the equivalent of saying it is not clear whether physicians have an obligation to treat a corpse, since, months before, the Massachusetts Supreme Judicial Court had accepted an even broader definition of brain death than the Harvard criteria. *Commonwealth v. Golston*, 1977 Mass. Adv. Sh. 1778, 336 N.E.2d 744 (1977), discussed at note 55 *infra*. (The memorandum quoted from *Golston*, but argued that it is not controlling since it only defined death for the purposes of criminal and not civil liability. *Id.* at 4. The memorandum made the incredible suggestion that if all the Harvard brain death criteria are met, "[t]he next of kin of the patient should be consulted about disconnecting the equipment, and their written consent (including a release from liability) should be obtained." *Id.* at 5. Phrased another way, this policy says that physicians should continue to treat dead people until the family releases them from liability for not treating the corpse.

The hospital's physicians were further urged not to "specify any one event as the date of death" but to note three different times: "the time and date on which the last test establishing brain death was completed, the time and date on which any artificial life support equipment was disconnected and the time and date on which the heartbeat stopped." *Id.* at 5. The attorney did not suggest whether one of these three, or all of them, should be entered on the death certificate.

The memorandum advised not writing an "order not to resuscitate" without a prior court order, and suggested that the *Saikewicz* court requires this. *Id.* at 5. See the discussion of the *Dinnerstein* case, *infra* note 58 and accompanying text, on this point. It is, of course, no accident that *Dinnerstein* was a patient at the Newton-Wellesley Hospital, and that the hospital was represented by the same firm that wrote this memorandum. The memorandum, which was signed by Ronald B. Schram for Ropes & Gray, concluded by advising that "in

of cases described above, primarily because hospital administrators have asked their legal counsel how the hospital could be protected from *any* possible liability.⁵⁴ The quest for "100 percent immunity" is both unrealistic and unprofessional, and evidences a desire to put one's self-interest above the interest of individual patients. So pervasive is the desire for self-pro-

some cases" the attending physician and the hospital should be represented by separate legal counsel "to avoid possible conflicts of interest." It finally noted that although legislation is being drafted, "[i]t is unlikely . . . that satisfactory legislation will be approved in the near future." *Id.* at 7.

Similar advice was followed outside of Boston. On June 7, 1978, for example, the medical staff of the Cape Cod Hospital received a memorandum from their chief, William P. Luke, saying: "The hospital attorney has informed us that the recent *Saikowicz* [*sic*] decision requires that a patient may no longer be 'no coded.'"

⁵⁴ A similar request in 1957 has led to more than two decades of continuing, and arguably unnecessary, litigation.

In that year the president of Boston's Peter Bent Brigham Hospital asked counsel's opinion "as to the civil and criminal liability of the Hospital and its trustees, officers and employees" if the hospital permitted its physicians to transplant a kidney from a healthy 14-year-old into his dying twin. The lawyers who responded to the letter misunderstood the only case they found on point, *Bonner v. Moran*, 126 F.2d 121 (D.C. Cir. 1941). While they are in good company in this misunderstanding, a careful reading of the case discloses that it stands for the proposition that if a child *and* his or her parents consent to a procedure that does not provide the minor with any benefits, and, indeed, may cause the child harm, the procedure may be performed. Accordingly, counsel could have answered simply that if the donee understood the nature and consequences of his acts, *and* consented to the donation, *and* the parents consented, the procedure could lawfully be performed. Instead, counsel advised that the parents had no authority to consent to the kidney transplant. Counsel concluded, without case citation, that there was also "a serious danger that the procedure would involve criminal liability." The memorandum is reprinted in KATZ, *EXPERIMENTATION WITH HUMAN BEINGS* 964-67 (1972). Since *Bonner* was not a Massachusetts case, and was decided before the Nuremberg Code (which set international standards for human experimentation) had been enunciated, it could be argued that counsel correctly decided not to rely on it. But these were not the reasons counsel gave for not relying on the case, nor do they explain his misreading of it. Counsel relied on two Massachusetts cases, *Banks v. Conant*, 96 Mass. (14 Allen) 497 (1867), and *Taylor v. Mechanics' Savings Bank*, 97 Mass. 345 (1867), holding that a parent cannot recover money paid to a child upon his voluntary enlistment in the Armed Forces. In dicta, one court said that parents had no authority to force their son to enlist against his wishes, and that the money was paid as an inducement "to undertake a service of an arduous and hazardous nature." 96 Mass. (14 Allen) at 498. None of this contradicts the holding of the *Bonner* case, nor is it inconsistent with the view that the consent of both the minor and the parents is sufficient to avoid liability.

At any rate, the Peter Bent Brigham Hospital had a number of options. It could perform the procedure anyway, relying upon the consent of the minor and his parents; it could refuse to perform the procedure; or it could go to court and seek a declaratory judgment that what it was doing was legal and that the court should so declare and further guarantee that it would be free from civil or criminal liability. The hospital opted for the latter course, and thus began a series of Massachusetts cases which now have covered more than 21 years, in which hospitals and physicians routinely seek immunity for performing surgery on minor donees involved in both kidney transplants and bone marrow transplants.

On children's consent to transplants, see ANNAS, GLANTZ, & KATZ, *INFORMED CONSENT TO HUMAN EXPERIMENTATION: THE SUBJECT'S DILEMMA* 75-87 (1977); on the bone marrow cases; see Baron, Botsford, & Cole, *Live Organ and Tissue Transplants from Minor Donors in Massachusetts*, 55 B.U.L. REV. 159 (1975).

tection that in a number of instances even brain-dead corpses have been brought to court for judicial permission to cease "treatment."⁵⁵ While one need not be surprised that lawyers and hospital administrators would involve themselves in such proceedings, it comes as somewhat of a surprise that the physicians of these brain-dead patients did not effectively oppose such action. Physicians should know at least enough law to be able to tell when the advice their lawyers are giving them is so incredible that it is most likely wrong.⁵⁶ They also should recognize that like physicians, dif-

⁵⁵ Months before the *Saikewicz* opinion, the supreme judicial court had accepted the following definition of death in a homicide case:

Brain death occurs when, in the opinion of a licensed physician, based on ordinary and accepted standards of medical practice, there has been a total and irreversible cessation of spontaneous brain functions and further attempts at resuscitation or continued supportive maintenance would not be successful in restoring such functions.

Commonwealth v. Golston, 1977 Mass. Adv. Sh. at 1780-81, 366 N.E.2d 747-48. Thus, when a physician says you're dead under the above criteria, which, as the court noted in *Saikewicz* include the Harvard brain-death criteria, you are dead beyond a reasonable doubt. Therefore, no criminal sanctions can be applied for not treating a brain-dead individual. However, since Golston left open the issue of when death occurs for civil purposes, some lawyers thought that civil immunity required a probate court order. The reason why the court left this issue open, however, is that other considerations, such as a fair distribution of an inheritance, might govern—for example, in a will contest involving simultaneous death, where one spouse had been maintained an additional day on a ventilator and declared brain-dead only thereafter. But *none* of these considerations would affect the physician's duty to treat, since when you're dead beyond a reasonable doubt, you're obviously dead by a preponderance of the evidence. In either event, there is no criminal or civil duty to treat a dead person, and taking such cases to court demonstrates great confusion on the part of the lawyers involved and an incredible fear of potential liability on the part of physicians and hospitals. In my opinion, the courts rightfully refuse to hear these cases. Two such cases are described briefly in Annas, *After Saikewicz: No Fault Death*, HASTINGS CENTER REP., June 1978, at 16, 17.

Nineteen states have adopted new statutory definitions of death, and in August, 1978, the National Conference of Commissioners on Uniform State Laws approved and recommended for enactment in all the states the Uniform Brain Death Act, with the following provision:

For legal and medical purposes, an individual who has sustained irreversible cessation of all functioning of the brain, including the brain stem, is dead. A determination under this section must be made in accordance with reasonable medical standards.

The comment to the Act notes that it "does not preclude a determination of death under other legal or medical criteria," and that the word "functioning" "expresses the idea of purposeful activity." National Conference of Commissioners on Uniform State Laws, Uniform Brain Death Act (July 28-Aug. 4, 1978).

See generally R. VEATCH, *DEATH, DYING AND THE BIOLOGICAL REVOLUTION* 21-72 (1976); Capron & Kass, *A Statutory Definition of the Standards for Determining Human Death: An Appraisal and a Proposal*, 121 U. PA. L. REV. 87 (1972); Kennedy, *The Kansas Statute on Death—An Appraisal*, 285 NEW ENGLAND J. MED. 946 (1971); Veith, *et al.*, *Brain Death—II. A Status Report of Legal Considerations*, 238 J.A.M.A. 1744 (1977).

⁵⁶ Most physicians, unfortunately for them and their patients, don't even learn enough law in medical school to do this. The 89th Annual Meeting of the Association of American

ferent lawyers may have different opinions about the law, and it sometimes pays to get a second or third opinion when your lawyer tells you that you must do something you think is wrong. Finally, physicians should realize that there are no 100 percent guarantees in law any more than in life, and that part of being a professional is taking responsibility for decisions within one's professional competence.⁵⁷

Medical Colleges included a panel on "legal medicine" on October 26, 1978, in New Orleans. This was the first time anyone attending this session could recall time being given to this topic at the annual meeting. At the session, Barbara Grumet, of the Albany Medical School's Center for Health Law, reported on the results of her questionnaire survey of 118 medical schools. Of the 99 respondents, 39 claimed at least one such elective. Nevertheless, the coverage and quality of these courses were extremely uneven, with the number of hours ranging from 2 to 80.

At Boston University School of Medicine for the past four years we in the Department of Socio-Medical Sciences and Community Medicine have had a required 16-hour seminar, given near the end of the first year, in "Law and Medicine: The Rights of Patients and Their Providers." The objectives of this seminar are (1) to introduce medical students to basic legal concepts and procedures; (2) to change students' attitudes so that they will view the law as an important tool in their work, rather than as an obstruction; (3) to encourage students to develop patterns of self-education so that they will continue to explore legal issues; and (4) to provide students with enough information so that they will have an idea of how lawyers think and will be able both to spot a legal problem and to determine whom to approach for help in resolving it. See generally Annas, *Law and Medicine: Myths and Realities in the Medical School Classroom*, 1 AM. J. L. & MED. 149 (1975), and articles cited therein.

⁵⁷ Even though the quest for professional immunity seems almost unending (*but see* Relman, *supra* note 5), it is primarily founded on ignorance and fear rather than knowledge and acceptance of professional responsibility. For example, while no physician has ever been successfully sued for stopping and rendering aid to a person experiencing a medical emergency, nervous medical societies have gotten all 50 states to pass statutes immunizing physicians against suit for negligence if they do stop. Even after some of these statutes were passed, the AMA reported that only half of the physicians surveyed in 1963 said they would stop, and the response rate was unaffected by whether the state had adopted a Good Samaritan statute. REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE, HEW PUB. NO. (OS)73-88, at 16 (1973). Similarly, in cases of medical staff discipline and reporting incompetent physicians to state licensing boards, physicians have demanded immunity from defamation suits, although almost no lawsuits have been filed in such cases. Further, the passage of these immunity statutes has not had a noticeable effect on physician disciplinary proceedings or on physicians' reporting of their colleagues to licensing authorities, recent AMA assertions to the contrary notwithstanding. See, e.g., AMA IMPAIRED PHYSICIAN NEWSLETTER, Dec. 1978, at 3.

Granting physicians immunity for the performance of their professional duties should almost always be seen as against public policy. Either physicians are acting as physicians—that is, treating and diagnosing patients according to their own professional ethics and "accepted medical practice"—or they are acting as nonphysicians and making decisions on some social policy grounds. If they are acting as physicians, they should be held accountable for their actions as physicians. Granting immunity in such cases is completely inappropriate, since it denies innocent potential victims compensation and encourages negligence. On the other hand, if physicians are engaged in making social policy decisions, it is even more counterproductive to grant them immunity, because with immunity they will be free to act without either knowledge or responsibility. See Annas, *After Saikewicz: No Fault Death*, HASTINGS CENTER REP., June 1978, at 16.

Professor Robert Burt argues analogously that courts should not consider granting declaratory judgment in cases involving nontreatment of defective newborns, because only

Legal advice once given is not easily withdrawn. For example, an attorney from a large Boston law firm advised a major suburban hospital to go to court to determine if it was proper to put a "do not resuscitate" order on Shirley Dinnerstein, a 67-year-old woman with Alzheimer's disease—a progressive and unremitting degenerative brain disease for which there is no cure—who, at the time of the petition, was completely paralyzed on her left side, in an essentially vegetative state, immobile, speechless, unable to swallow without choking, and barely able to cough. Her condition was "hopeless." It apparently came as a surprise to some that the Massachusetts Appeals Court had no difficulty finding that this was *not* the type of case that the *Saikewicz* court held belonged in court, since there was nothing medical science had to offer this patient.⁵⁸

This same attorney then co-authored a legal advice column on this case in *The New England Journal of Medicine*. The column stands as a classic,

by putting both parents and physicians in some personal jeopardy can we insure that their actions are likely to be fair to the child involved:

The true enormity of these actions to withhold life from newborns, viewed from our contemporary perspective, will remain in high visibility only if *advance social authorization is withheld*, and only if the parents and physicians who wish to take this action are willing to *accept some significant risk* that they will suffer by such action. Their suffering will come in increasing intensity if criminal prosecution is instituted, if a jury finds them guilty of unconscionable conduct and if a judge imposes sanctions on them accordingly. In deciding whether to withhold treatment from the newborn, the parents and physicians will be led to balance the suffering imposed on them by the continued life of the child against the suffering likely from their decision to end the child's life.

Burt, *Authorizing Death for Anomalous Newborns*, in GENETICS AND THE LAW 435, 444 (A. Milunsky and G. Annas eds. 1976) (emphasis added). *Accord*, *In re Nemser*, 51 Misc. 2d 616, 273 N.Y.S.2d 624 (Sup. Ct. 1966) (petition for guardian to consent to treatment denied on basis that decision was a medical one for which immunity was inappropriate). *See also* Spencer, "Code" or "No Code": A Nonlegal Opinion, 300 NEW ENGLAND J. MED. 138 (1979) ("Sounding Board"), which argues, "As physicians we have an obligation to keep our priorities straight; to do always what we consider to be in the best interests of our patients and in keeping with our moral and ethical precepts." *Id.* at 140.

⁵⁸ *In re Dinnerstein*, 1978 Mass. App. Adv. Sh. 736, 380 N.E.2d 134 (1978). In the court's words:

The judge's findings make it clear that the case is hopeless . . . Attempts to apply resuscitation, if successful, will do nothing to cure or relieve the illnesses . . . The case does not, therefore, present the type of significant treatment choice or election which, in light of sound medical advice, is to be made by the patient, if competent to do so . . . This case does not offer a life-saving or life-prolonging treatment alternative within the meaning of the *Saikewicz* case.

Id. at 746, 380 N.E.2d at 138-39. The Executive Director of the hospital involved—Newton-Wellesley—described the role of his hospital in the *Dinnerstein* case: "We took leadership in resolving the ambiguities surrounding the state Supreme Court's decision in the *Saikewicz* [sic] case and obtained a ruling that restored the right of patients to die in peace." Christenson, 1977-78: A Special Year, NEWTON-WELLESLEY QUARTERLY, Dec. 1978, at 18 (emphasis added). *See also* note 53 *supra*.

illustrating Professor Sylvia Law's observation that "professional medical publications frequently offer statements about legal standards which are casual, offhand, misleading, or just plain wrong."⁵⁹ It is arguably all of these. It incorrectly asserts, for example, that the appeals court decision in *Dinnerstein* is "final authority" in Massachusetts since "it was not appealed." The article is also an attempt to justify the previous legal advice of the writers to their clients,⁶⁰ by arguing that the *Dinnerstein* court supports their view that *Saikewicz* "appeared to establish a rule of law that unless such a court determination has been obtained, it is the duty of a doctor attending an incompetent patient to employ whatever lifesaving or life-prolonging treatments the current state of the art has put into his hands."⁶¹ This is, of course, dicta. The holding of the case—that one does not have to get prior court approval for an order not to resuscitate a hopeless patient—is just the opposite.

Nevertheless, this column is likely to be taken as "the law" by many Massachusetts physicians, thus compounding current confusion. For example, Dr. Charles A. Sanders, General Director of the Massachusetts General Hospital, recently wrote in *Hospitals* that the opinion in *Dinnerstein*

⁵⁹ LAW & POLAN, *supra* note 47, at 116.

⁶⁰ See note 53 *supra*.

⁶¹ Schram, Kane, & Roble, "No Code" Orders: Clarification in the Aftermath of *Saikewicz*, 299 NEW ENGLAND J. MED. 875, 877 (1978) ("Law-Medicine Notes"). One reason the *Dinnerstein* case even merited mention in *The New England Journal of Medicine* is because of the confusion generated by previous articles and letters in the *Journal* itself. As the *Dinnerstein* court noted, citing two such pieces, its opinion was seen to be necessary by the plaintiffs because *Saikewicz*

has been interpreted by some in the medical profession as casting doubt upon the lawfulness of an order not to attempt resuscitation of an incompetent, terminally ill patient except where the entry of such an order has been previously determined by a Probate Court to be in the best interests of the patient.

1978 Mass. App. Adv. Sh. at 740-41, 380 N.E.2d at 136 (emphasis added). At one point Schram, Kane, and Roble argue that the consent of the "'immediate family' should be sufficient" in "no code" situations, and cite two cases, *Belger v. Arnot*, 344 Mass. 679, 183 N.E.2d 866 (1962), and *Reddington v. Clayman*, 334 Mass. 244, 134 N.E.2d 920 (1956), for that proposition. Schram, *et al.*, *supra*, at 876. Neither of these cases has anything to do with a terminally ill patient; *Reddington* involved the consent of a father to have his daughter's tonsils removed, and *Belger* involved the involuntary commitment of a wife to a mental institution under a procedure that has since been changed by statute. At another point in the article the authors string together three cases, *In re Custody of a Minor*, 1978 Mass. Adv. Sh. 2002, 379 N.E.2d 1053 (1978), *Commonwealth v. Golston*, 1977 Mass. Adv. Sh. 1778, 336 N.E.2d 744 (1977), and *In re Dinnerstein*, 1978 Mass. App. Adv. Sh. 736, 380 N.E.2d 134 (1978), which they assert stand for the proposition that it might be permissible for "a competent patient who is not irreversibly, terminally ill . . . to refuse resuscitation measures whenever his decision would, in the judgment of a competent and reasonable physician, be consistent with 'good medical practice'." Schram, *et al.*, *supra*, at 876. None of the three cases cited involved a competent patient (*Golston* was a murder case, *Custody of a Minor* involved a two-year-old child, and the other case was *Dinnerstein* itself). It is, of course, not competent patients, but competent physicians who are legally required to make decisions consistent with "good medical practice."

"effectively removed from the courts the medical decision-making process in virtually all circumstances in which heroic measures might ultimately be used to sustain life,"⁶² apparently because he thought *Dinnerstein* overruled *Saikewicz*.

The distortions of *Dinnerstein* continue a story begun with misinterpretations of the scope of both *Quinlan* and *Saikewicz*. Hospital administrators are worried about legal liability. Physicians are worried about both legal liability and professional autonomy. Hospital counsel are generally untrained and inexperienced in health law. Neither physicians nor hospital administrators know how lawyers think, how to ask them for advice, or what to do with legal advice that doesn't seem to make sense. Consequently, we have a growing number of physicians and hospital administrators arguing about the merits of judicial opinions they do not understand. They castigate the *Saikewicz* court for doing something it did not do, and commend the *Quinlan* court for something it did not do.

IV. CONCLUSION

The next state supreme court that speaks on the issue of withholding treatment from the terminally ill incompetent will have the opportunity to synthesize and reconcile the *Saikewicz* and *Quinlan* decisions clearly and with a full discussion of the proper role of both professional medical judgment and judicial decision making. No one wants a system in which all treatment decisions for incompetents are made by judges, or one in which they are all made by physicians. Nor does anyone want a system where the rights of the weakest members of society—the incompetent terminally ill—are not fully protected. It is critical that the rights of these patients be viewed as worthy of the full protection of the law.⁶³ On the other hand, it is equally critical that physicians not practice medicine solely with a view toward avoiding liability. As Alexander Solzhenitsyn warned in his much maligned commencement address at Harvard University,

⁶² Sanders, *Medical Technology: Who's to Say When We've Had Enough*, HOSPITALS, Nov. 16, 1978, at 66, 68. It is, of course, *Saikewicz* which continues to be the only "final authority" in Massachusetts, any reading of *Dinnerstein* to the contrary notwithstanding.

⁶³ See, e.g., R. DWORKIN, *TAKING RIGHTS SERIOUSLY* 205 (1978):

The bulk of the law—that part which defines and implements social, economic, and foreign policy—cannot be neutral. It must state, in its greatest part, the majority's view of the common good. The institution of rights is therefore crucial, because it represents the majority's promise to the minorities that their dignity and equality will be respected. When the divisions among the groups are most violent, then this gesture, if law is to work, must be most sincere.

. . . [Taking rights seriously is] the one feature that distinguishes law from ordered brutality.

while a society without any objective legal scale is "terrible," "a society with no other scale but the legal one is not quite worthy of man either":⁶⁴

A society that is based on the letter of the law and never reaches any higher is taking small advantage of the high level of human possibilities. The letter of the law is too cold and formal to have a beneficial influence on society. Whenever the tissue of life is woven of legalistic relations, there is an atmosphere of mediocrity, paralyzing man's noblest impulses.

Many have argued that such mediocrity and paralysis already have set in, as evidenced by the increase in medical malpractice litigation and its resulting practice of both negative and positive defensive medicine. Certainly the post-Saikewicz experience tends to confirm the *Quinlan* court's conclusion that "self-protection" has a strong influence on medical practice. My argument is that such a negative reaction to the law on the part of medicine is primarily motivated by ignorance, perpetuated in part by some leading medical journals. Insofar as this argument is correct, it is optimistic. It postulates that increased understanding by the medical community of the law and the legal process will lead to more personalized medical treatment decisions for competent and incompetent patients alike.⁶⁵

⁶⁴ Solzhenitsyn, *The Exhausted West*, HARVARD MAGAZINE, July/Aug. 1978, at 22.

⁶⁵ This is not to say that society will soon, or ever, agree on a way to make all treatment decisions for the incompetent terminally ill patient. Indeed, since it is often a choice between death and continued suffering, the choice can be characterized as a "tragic choice," and as such one that can be made only by sacrificing, or seeming to sacrifice, one or more societal values for others (for example, the universal sanctity of human life versus self-determination). In such situations one often sees a transfer of decision-making authority from one group to another or from one forum to another, as specific societal values are threatened. An "arresponsible" agency such as a jury or an ethics committee, for example, will be chosen to apply societal standards but not required to articulate them either because such an articulation would destroy their effectiveness (as when a decision not to treat is based on the fact that the patient is mentally retarded), or because the values on which the decision seems to be based do not exist (for example, all persons must be treated equally). The attractiveness of "para-juries" has led to their adoption in such settings as human experimentation (Institutional Review Boards) and kidney dialysis. However, when a para-jury sits on more than one case, a pattern of decision making either develops or it does not. If it does, the pattern can be articulated and applied without using the para-jury. If it does not, the para-jury is open to the challenge of arbitrariness, and a lottery, or first-come-first-served method, may prove a fairer and more efficient method of allocating scarce medical resources.

These problems were illustrated in *Furman v. Georgia*, 408 U.S. 238 (1972), in which the majority's attack on the discretionary power of juries in capital punishment cases was based both on the perception of the intolerable discrimination on the one hand, and the notion that the almost random manner in which the death sentence was being imposed constituted cruel and unusual punishment on the other. A judge may be a better decision maker than a para-jury concerning whether to treat a terminally ill incompetent patient, because the elements of process in a judicial proceeding—for example, representation of the patient, required articulation of the reasons for the decision, and the opportunity to appeal—are superior to those in a para-jury proceeding. Nevertheless, it may be that when treatment

We will all die. And we need not view death as "sweet," "kind," or "gentle" to favor the development of a system likely to assure us of the primary voice in determining how we will be treated when we are near death. In this regard, promoting the rights of the terminally ill incompetent is likely to benefit everyone.

is advocated, judges will always require it, and this method might have to be abandoned for another, if society determines that the financial expenditures for these patients cannot be justified. The point is that decisions *must* be made, and each method of making a "tragic choice" will necessarily involve major problems which will bring societal values into conflict. Recognizing this, our task is to develop that method of conflict resolution which reaches fair and just decisions as often as possible without destroying important societal values. *See* G. CALABRESI & P. BOBBITT, *TRAGIC CHOICES* (1978). *See also* Havighurst, Blumstein, & Bovbjerg, *Strategies in Underwriting the Costs of Catastrophic Disease*, 40 L. & CONTEMP. PROB., Autumn 1976, at 122, 178-95, in which the authors suggest ways in which structuring financing mechanisms for catastrophic diseases may aid in private decision making. *See also*, on the issue of public policy and decision making for the catastrophically ill, J. KATZ & A. CAPRON, *CATASTROPHIC DISEASES: WHO DECIDES WHAT?* (1975); Annas, *Allocation of Artificial Hearts in the Year 2002: Minerva v. National Health Agency*, 3 AM. J. L. & MED. 59 (1977).